PACIFIC BRAIN & SPINE
MEDICAL GROUP

Medical History

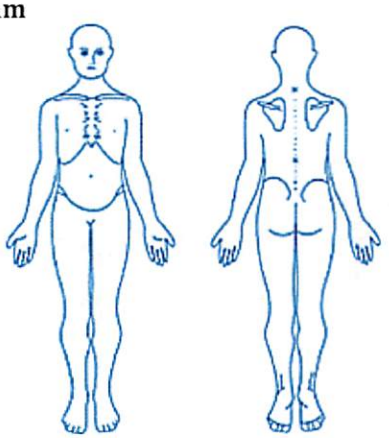
Name: _____ **Today's Date:** _____
How do you prefer to be addressed by our physicians and staff? _____
Your Occupation: _____

1. Age: ____years **2. Are you right or left handed?** ☐ Right ☐ Left **3. What is your height?** _____
weight? _____

4. Describe the condition/problem that you want to address at this visit:

5. Is this condition the result of an accident? ☐No ☐Yes – Explain

6. Please indicate pain with an "X" on the diagram
7. Please indicate numbness/tingling with an "O" on the diagram



8. Current Medications - Please list

9. Past Medical History: Do you have any of the following?

Diabetes ☐No ☐Yes
Hypertension ☐No ☐ Yes
Heart Disease ☐No ☐ Yes –Explain _____
Bleeding Prob. ☐No ☐Yes –Explain _____
Cancer/Tumors ☐No ☐ Yes –Explain _____
Other medical conditions: _____

10. Previous Surgeries / Dates- Please List

11. Do you have any allergies to medications?
☐No ☐ Yes - Please List

Medication Causing Reaction	Reaction

12. Have you ever had problems with anesthesia? ☐No ☐ Yes - Explain_____

13. Family History: Check boxes for any close relatives (parents, siblings, children) with:

☐ Diabetes ☐ Hypertension ☐ Heart Disease If yes, what relative?_____

☐ Spinal problems ☐ Aneurysm ☐ Stroke If yes, what relative?_____

14. Social History

Marital status: _____ Spouse/Partner name: _____

Tobacco: ☐ Never Smoked ☐ Former Smoker- Quit Date: _____

☐ Current User - Amount per day____ Type: ☐ Cigarettes ☐ Cigar ☐ Smokeless

Alcohol Use: ☐ No ☐ Yes - How many drinks per week: _____ Type_____

Other Drugs: ☐ No ☐ Yes - Explain_____

15. Review of Systems: Circle any positives

Constitutional:	**Fatigue**
	Fevers
	Weight Change
Eyes:	**Change in vision**
Ears/Nose/Throat:	**Neck Pain**
	Hearing Loss
	Swallowing Problem
Respiratory	**Shortness of breath**
	Wheezing
Cardiovascular	**Heart attack**
	CHF heart failure
	Arrhythmia
	Chest pain
Gastrointestinal:	**Ulcers**
	Bowel Problems
Genitourinary	**Incontinence**
	Urinary infections
Musculoskeletal	**Back Pain**
	Joint Pain
	Scoliosis
Skin	**Rashes**
	Leg Swelling
Neurologic	**Headache**
	Stroke
	Seizure
Psychiatric	**Confusion**
	Anxiety
	Depression
	Hallucinations
	Sleep disturbance

Other Conditions _____

_____ _____

Patient Signature **Date**